LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1	LICENSEE CODE	LICENSE NUMBER	LICENSE TYPE	CAT
	W I P B H 1 (2)	0 0 - 0 0 0 0 0 - 0 0 (3)	4 1 1 1 1 (4)	(5)

CON'T 0 1	REPORT SOURCE	DOCKET NUMBER	EVENT DATE	REPORT DATE
	L (6)	0 5 0 0 0 2 6 6 (7)	0 6 2 1 8 3 (8)	0 7 1 8 8 3 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal operation the breaker which serves MOV-826B was found to
0 3 be open. The redundant valve MOV-826C was not tested for operability
0 4 prior to the disabling of MOV-826B which constitutes a violation of
0 5 TS 15.3.3.A.2.c. MOV-826B&C are isolation valves which are located be-
0 6 tween the SI pumps and the boric acid storage tank. No significant
0 7 occurrence took place as a result of this event. Reference previous
0 8 type event LER No. 77-001, Unit 2.

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	S F (11)	X (12)	Z (13)	C K T B R K (14)	A (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 0 4	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
X (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	W 1 2 0 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 An investigation of the event has been performed and no explanation has
1 1 been found. The most probable cause is believed to be an accidental
1 2 opening of the breaker by personnel. The breaker was closed as soon as
1 3 it was found to be open. Subsequent testing proved all valves functioned
1 4 properly.

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	E (28)	0 7 8 (29)	N/A	B (31)	Operator observation during insp.

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	N/A

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)
	N (44)	N/A

NRC USE ONLY

NAME OF PREPARER C. W. Fay PHONE: 414/277-2811

ATTACHMENT TO LICENSEE EVENT REPORT NO. 83-004/03L-0

Wisconsin Electric Power Company
Point Beach Nuclear Plant, Unit 1
Docket No. 50-266

On June 21 at 1404 hours breaker 1B42-5J, which feeds the valve operator for 1MOV-826B, was discovered to be open during routine operator surveillance. At 1409 hours the breaker was reclosed. The state of this breaker is checked prior to each operator shift change (every 8 hours). At 0604 hours on June 21 this MOV was checked and its status was found to be normal. Also, the operator is confident that while performing a separate operation at 0937 hours on June 21 he noticed that the MOV was in its normal state. Therefore, sometime between 0937 hours and 1404 hours on June 21 breaker 1B42-5J was opened. It should be noted that this breaker was found in the open, not tripped, position. Valves 1MOV-826A, 1MOV-826B, and 1MOV-826C were tested per inservice test IT-120 on June 23 at approximately 0700 hours and were found to be in good working order.

An investigation of this event has revealed no information as to why or how breaker 1B42-5J came to be opened. The most probable cause of this event is that the breaker was opened accidentally by some person walking past the MCC. This particular breaker is located at elbow height in a high traffic area of the auxiliary building which gives some plausability to the accident theory.

Valves 1MOV-826B and 1MOV-826C are normally closed isolation valves located between the boric acid storage tank and the safety injection pump inlets. The two valves are redundant, and sized and arranged so that either one can supply concentrated boric acid to both "A" and "B" train pumps. If the safety injection pump had been called on to start while MOV-826B was unavailable, 1MOV-826C would have opened and supplied sufficient coolant to both safety injection pumps. If 1MOV-826C had not begun to open within two seconds after the receipt of a safety injection pump start signal, then MOV-825 A&B would have opened to supply coolant from the refueling water storage tank.

An investigation will be performed to determine the feasibility of installing protective devices over critical MCC's to prevent accidental breaker tripping in the future.

Wisconsin Electric POWER COMPANY
231 W. MICHIGAN, P.O. BOX 2046, MILWAUKEE, WI 53201

July 18, 1983

Mr. J. G. Keppler, Regional Administrator
Office of Inspection and Enforcement,
Region III
U. S. NUCLEAR REGULATORY COMMISSION
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Dear Mr. Keppler:

DOCKET NO. 50-266
LICENSEE EVENT REPORT NO. 83-004/03L-0
POINT BEACH NUCLEAR PLANT, UNIT 1

Enclosed is Licensee Event Report No. 83-004/03L-0 (a 30-day report) with an attachment which provides a description of an event reportable in accordance with Technical Specification 15.6.9.2.B.2, "Conditions leading to operation in a degraded mode permitted by a limiting condition for operation or plant shutdown required by a limiting condition for operation."

Very truly yours,

C W Fay

Vice President-Nuclear Power

C. W. Fay

Enclosure

Copy to NRC Resident Inspector

JUL 21 1983
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